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ALCOHOLISM AND MONTANA INDIAN PEOPLE

TOWARD AN OFF-RESERVATION SOLUTION

by

Clint Grimes

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MONTANA STATE
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A study prepared by

The Montana United Indian Association

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INTRODUCTION

This study, prepared by the Montana United Indian Association under contract with the Addictive Diseases Bureau of the Montana State Department of Institutions, is an effort to approach what is obviously a serious state problem. Alcoholism among Montana's Indian people has reached a level demanding action based on a commitment by Indian people and by the State of Montana. This study outlines the extent of the problem and suggests courses of action to be taken. It is based on interviews with people knowledgeable about Montana's Indian people and about alcoholism. Indian people must solve the problem but they need assistance. The recommendations in the study outline the nature of that needed assistance.

Clint Grimes

Indian People of Montana

The mobility of Montana Indian people between reservations and off-reservation locations has always frustrated the efforts of census takers. The typical tendency has been to err on the conservative side in estimating Montana's Indian population. The 1970 census estimates Indian population in Montana as 27,130 for both on and off-reservation Indians. A more recent study (1974) done by Urban Management Corporation (UMC) under contract to the State of Montana estimates 36,710 on and off-reservation Indians in the state. UMC, using data from the census, Bureau of Indian Affairs and Montana United Indian Association, regards even this figure as a conservative estimate of Montana's total Indian population.[1]

A more realistic estimate in 1977 would place the Montana Indian population at approximately 50,000. These people include those on seven reservations representing 14 major tribal groupings, and another loosely associated band called Landless Indians or alternately the Turtle Mountain Band and off-reservation Indians.

Regardless of the estimates used, the Indians of Montana represent the largest single minority group in the state. Approximately one out of every 20 Montana citizens is an Indian. More significantly, from the prospective of this report, there is high mobility of Indians within Montana between reservations, rural towns and other off-reservation cities. Job seeking accounts for most of the movement away from

[1] Profile of the Montana Native American, Office of the Governor, Helena, MT 1974, p. 17.

the economically deprived reservations to Montana cities. The result is that at any given time roughly half the state's Indian population is residing at locations away from the reservations with the major concentration of these off-reservation Indian peoples in the cities served by MUIA's Indian Alliance Centers. MUIA's eight alliances have documented the presence of 12,000 Indians living off reservations in the eight cities served by the alliances. The current director of the Federal Office of Native American Programs has indicated that the rate of movement away from reservations to cities is increasing nationwide and Montana is no exception.

Included among this off-reservation Indian population are the young, the job seekers, and in keeping with the cultural traditions of the Northern Plains Indian -- the old.

Conditions on the reservation -- unemployment, boredom, etc., and a desire to test and see the outside world probably account for this mobility. The reservation is, however, the only remaining territorial base for many of Montana's Indians. Whatever hardships exist there and however bleak the prospects there, relatives live there and these strong family ties and the ties to the land are compelling attachments among Montana's Indian people to these reservation bases. And, so, because of these twin desires -- to participate in the white culture and return to the only remaining land base of Indian culture -- there exists a high mobility between on and off-reservation locations for most of Montana's Indian people.

From the standpoint of white culture, there is a striking fact

about this Indian mobility, however. Montana Indian mobility has, in general, a very short geographical range. While mobility in white culture is characterized by wide dispersion of family, over thousands of miles, Montana Indian people generally confine their dispersions to a few hundred miles at most and usually remain in the state of Montana or among Indian groups near Montana's borders in Idaho and Wyoming. Families are very seldom separated by thousands of miles and spread across the continental United States as is commonly true of families in the white culture. For purposes of this study and specifically for comments on treatment approaches, this is a very important fact.

The Size of the Problem

Data bearing directly on the extent of alcoholism among Montana Indians is nonexistent. This state of affairs is not unusual due to the number of factors associated with accurate sampling of the disease characteristics of a given population. Even the data used for estimating alcoholism in the U. S. population lacks the necessary refinement of strict sampling tests and an estimate of a ten percent alcoholism rate in the national population is a gross estimate at best. Estimates of the rate of alcoholism among the U. S. Indian population have one characteristic in common -- they are very high. In Oregon, for instance, as reported by the Oregon Indian Commission on Alcohol and Drug Abuse,[1] more than eighty percent of all Indians over the age of fourteen abuse either alcohol or other drugs.

[1] 1975 State Plan on Alcohol and Drug Abuse; Oregon Indian Commission on Alcohol and Drug Abuse (Stewart L. Castro, Executive Director), 1975, P. 8.

The patterns of Indian alcoholism problems nationally was summed up in a statement before the Senate by Senator Edward Kennedy (D-Mass.): "The first area of concern, alcoholism, is probably the worst problem facing Indians." [1] Shortly after the Kennedy speech, NIAAA Director Morris Chafetz, appearing before the Senate Committee on Alcoholism stated that . . .

> " . . . alcoholism efforts have reached no more than twenty percent of the nation's Indians (and) it's completely unrealistic and primitive to assume that the needs of the Indians in alcoholism (have been met)." [2]

Practitioners in the field of alcoholism also recognize the severity of the alcoholism problems among Native Americans as differentiated from other ethnic groups.

James Milam points out: . . .

> " . . . It is estimated that some ten percent of all drinkers in the United States are alcoholics. However, the differential rates among ethnic groups are enormously varied, from a negligible rate below one percent for Jews, to something like eighty percent estimated for Indian and Eskimo groups." [3]

Whether one talks with the Indian people themselves, with professionals in the alcoholism field, or with leaders of Indian groups, estimates of alcoholism or drinking problems among Indian populations seldom go below 70 percent of the population. A generally accepted figure is 80 percent. In Montana most professionals interviewed in

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[1] JSL Reports; The Alcoholism Report: Newsletter for Professionals in the Field of Alcoholism: Vol. II, No. 13, April 26, 1974, P. 3

[2] JSL Reports; Ibid. P. 5

[3] James R. Milam, Ph. D.; The Emergent Comprehensive Concept of Alcoholism, ACA Press, Alcoholism Center Assoc. Inc. P. 37

this study estimate that 70 to 80 percent of off-reservation Indians have alcohol problems requiring some form of treatment. The director of the Galen Alcoholism Treatment Center in Montana estimates that approximately 25 percent of the center's patients in any given year are Indian. This means that one of every four patients at the Montana Alcoholism Treatment Center is Indian. Yet only one of every twenty Montanan's is Indian. It is notable in this regard that while each of Montana's seven reservations has an alcoholism treatment center, the central Montana facility, Galen, continues to have a disproportionately high percentage of Indian people in treatment from what could be expected on the basis of probability alone; and Galen is not unique. All four of the off-reservation treatment centers in Montana have a disproportionately higher rate of Indian clients than real Indian numbers in the population would predict. Table I outlines this phenomenon in a typical three-month period during 1976.

The inordinately large percentage of Indian clients in these five off-reservation treatment centers is a substantial indicator of the seriousness of alcoholism as a disease among Montana's Indian population. The fact that Indian people in such numbers are undergoing treatment reflects a recognition on the part of Indian people themselves, the health professions, and the court system that alcoholism is extraordinarily severe among this unique cultural minority in Montana.

Admissions to Montana alcoholism treatment facilities are not

the only indicators of the severity of the disease of alcoholism among Montana Indians both on and off-reservations.

Alcoholic Indians suffer extensively from many chronic, even fatal, alcohol-related disorders such as cirrhosis of the liver, beer-drinker's heart, wine-drinker's stomach, and rampant infections of the mucous membranes of the mouth and nose. Other lesser-known ailments such as Wernicke's Disease, Korsakoff's Disease, and alcoholic Pellegra are also attributed to alcohol misuse among Indians.[1]

In part, at least, the early age at death of Montana Indians could be traced to the physical deterioration consequent on both high rates of alcoholism and early age onset of alcoholism. The average age at death of American Indians nationally is 55 years of age. Tabel II shows that Montana Indians have a higher death rate at early ages than the national Indian averages. Montana's Aging Bureau has requested and received recognition of this early aging process and early death rate among Montana Indians. Several titles of the Social Security Act apply to Montana Indians beginning at age 45.

Moreover, professionals in the alcoholism treatment field in Montana have noted that alcoholism often occurs earlier among Indian people than among whites. This early age at onset of

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[1] National Institute on Mental Health; Alcohol and Alcoholism: National Institute on Alcohol Abuse and Alcoholism, Rockville, Maryland, 1972, P. 10

TABLE I

CLIENT INTAKES 1976

Treatment Center	July	Aug.	Sept.	3 Mo. Average
RIMROCK - BILLINGS				
White	37	49	48	45
American Indian	8	13	18	13
Other	3	2	9	2
Percent Indian	17%	20%	37%	22%
ARC-BILLINGS-DETOX				
White	45	47	47	46
American Indian	18	12	25	18
Other	2	1	2	2
Percent Indian	28%	20%	34%	27%
PROVIDENCE-GREAT FALLS				
White	27	31	40	33
American Indian	7	12	7	9
Other	1	0	0	0
Percent Indian	20%	28%	15%	21%
HILL-TOP				
White	24	26	18	23
American Indian	8	6	4	6
Other	0	0	0	0
Percent Indian	25%	19%	18%	21%
GALEN				
White	121	119	136	125
American Indian	35	28	33	32
Other	3	2	1	2
Percent Indian	22%	19%	19%	20%

The Indian percentage of the total Montana population is approximately five percent.

TABLE II

AGE SPECIFIC DEATH RATES OF MONTANA INDIANS

Age	Montana Indian Deaths (1972) No.	Montana Indian Deaths (1972) Rate per 100,000 pop.	All U.S. Indian * Deaths (1971) No.	All U.S. Indian * Deaths (1971) Rate per 100,000 pop.
Under 5 years	29	788.3	690	N/A
5 - 14 years	10	113.5	139	72.1
15 - 24 years	31	596.7	515	375.7
25 - 34 years	30	888.6	501	577.3
35 - 44 years	26	993.1	556	828.4
45 - 54 years	29	1527.9	631	1193.7
55 - 64 years	38	2800.3	720	1801.1
65 - 74 years	41	4270.8	798	3211.1
75 and over	42	9859.2	1018	N/A

* Includes all Indians living in the 24 states with Indian reservation services by Indian Health Service.

Source: Indian Health Service, Department of Health, Education, and Welfare, Washington, D.C.

alcoholism undoubtedly compounds the cycle of disease and accident related deaths that characterize the early age at death of Montana Indians. Table III shows admissions to the Galen State Hospital Alcoholism Treatment Center for a fairly typical two-month period in 1976. It is notable that the percentage of Indian patients in the younger age categories are considerably higher than comparable percentages for white patients.

The death rate profile contained in Table IV (which also includes Indians on Wyoming's Wind River Reservation), contains some pertinent data relating to the possible influence of a high alcoholism rate among Indians and high early death rates.

The accident categories in Table IV, for example, show substantially higher death rates among Montana and Wyoming Indians than rates for national or Montana populations as a whole. In the accident category alone, national estimates range from 50 to 60 percent of such accidents as being alcohol related. Extrapolated to these enormously high Indian accidental death rates, even the conservative 50 to 60 percent national alcohol relation accounts for a great number of Montana Indian deaths. It is very probable that the Montana Indians are five times more likely to die in an automobile accident than the average American. And, Montana Indians are over five times more likely to die of a homocide than the average Montanan. The true relation of alcohol to the Montana Indian accidental death rate is much higher than the 50 to 60 percent national relation.

TABLE III

AVERAGE AGE TABLE OF ALCOHOLISM ADMISSIONS FOR

OCTOBER AND NOVEMBER, 1976 - GALEN STATE HOSPITAL

Age Group	(0-20)	(21-35)	(36-50)	(51-65)	(66-75)	(over 75)
Indian Female		13	3	1		
Indian Male	2	23	19	8		
Total Indian	2	36	22	9		
Caucasian Female	1	10	11	9		
Caucasian Male	7	68	210	88	16	
Total Caucasian	8	78	221	97	16	
Age % of Indian Admissions	2.8	52.1	31.8	13.		
Age % of Caucasian Admissions	1.9	23.3	46.	19.8		

TABLE IV

SELECTED MORTALITY RATES OF MONTANA AND WYOMING INDIANS

1970 - 1972

Indian Deaths - Montana/Wyoming

	1970 - 1972		All Races	
	Total	Rate per 100,000 pop.	U.S. 1972	Montana 1970
Total Deaths	977	1014.2	942.2	950.0
Accidents	205	212.8	54.6	100.3
Motor Vehicle	(130)	(135.0)	(27.2)	(42.2)
All Other	(75)	(77.8)	(27.4)	(58.1)
Influenza and Pneumonia	49	50.9	29.4	31.8
Cirrhosis of Liver	45	46.7	15.7	14.1
Homicide	24	24.9	9.1	4.3
Suicide	32	33.2	11.7	11.3
Diabetes Mellitus	22	22.8	18.8	15.9
TB, All Form	7	7.3	2.2	1.7
Alcoholic Psychosis and Alcoholism	24	24.9	7.5	N/A

N/A - Not Available

Note: These figures represent statewide totals of all Indians, including those not residing in IHS service unit areas.
Population of 32,110 was used for 1970 - 1972 period.

Source: Indian Health Service, Billings Area Office; Bureau of Records and Statistics, Montana Department of Health and Environmental Sciences.

Table IV also indicates that the death rate among Indians due to cirrhosis is over three times higher than the national or Montana rate for all races. The relation of alcoholism to cirrhosis is a well established fact.

Morality rates in 1972, when data retrieval began, show Montana and Wyoming Indians over three times more likely to die of alcoholism and alcohol psychosis than people in the general U. S. population (See Table IV.)

Similarly, arrest rates for a selected group of off-reservation Montana cities indicate that the socio-legal consequences of Indian alcohol use are substantial in Montana cities. Table V shows misdemeanor alcohol-related arrests in the county seats of these counties and felony arrests in these cities. It is obvious from a comparison of the two tables that the Indian percentage of total arrests throughout the categories bears no relation to their real numbers in the population. An Indian is 30 times more likely to be arrested for drunkenness in Billings than population figures would predict. Undoubtedly, law enforcement practices account for part of this picture of high Indian arrest percentages, but even casual observation in these areas indicates that the level of arrests bear some real relation to alcohol-use patterns by Indians in these off-reservation cities.

TABLE V

MISDEMEANOR
ALCOHOL RELATED ARRESTS
JANUARY 1, 1975 THROUGH DECEMBER 31, 1975

	Indians	Total	Percent	Indian % County Pop.
BILLINGS - Yellowstone County				1.2
Disturbing the Peace	65	347	19%	
Theft	71	698	10%	
Drunk	56	160	35%	
Drunk Driving	32	306	10%	
Possession of Alcohol	4	66	6%	
Total All Arrests	334	2807	12%	
GREAT FALLS - Cascade County				1.8
Riotous Conduct	50	187	27%	
Drunk	116	253	46%	
Drunk Driving	16	157	10%	
Total All Arrests	554	2241	25%	
HAVRE - Hill County				9.3
Riotous Conduct	52	90	58%	
Disturbing the Peace	90	48	53%	
Theft	48	95	51%	
Drunk	62	87	71%	
Drunk Driving	16	89	20%	
Possession of Alcohol	15	36	42%	
Total All Arrests	409	1733	24%	

FELONY ARRESTS

BILLINGS	51	645	8%
GREAT FALLS	184	666	28%
HAVRE	17	61	28%

Recognition

Data in the preceding pages illustrate some of the health and socio-legal consequences of alcoholism among Montana Indians. Only by inference do they suggest the enormous cost in human suffering. Recognition of Indian drinking problems has become a racist cliche among non-Indians. Non-Indians, including the American Congress in the Indian Intercourse Act of 1832 have attempted to thwart Indian consumption of alcohol. States and counties have also attempted to restrict Indian drinking. These efforts by non-Indians have had two important consequences. First, they have not reduced Indian comsumption of alcohol and second, they have reinforced Indian people's view that the white man is prepared to discriminate against the Indian on any pretext. Often these discriminatory acts by non-Indians, including public officials, are masked with good intentions when in reality they have another purpose. In 1977 in Montana, for example, the State Legislature's Chief Fiscal Analyst released a report on a proposal to sell wine in grocery stores. The report suggested that raising the drinking age of all Montanans and restricting sales of wine "around Indian reservations" could reduce the adverse social impact of the relationship between wine availability and alcoholism.

Great Falls Tribune, January 13, 1977

> "The 1976 study showed that putting wine on grocery store shelves would lead to lower prices, greater accessibility, larger variety of brands, increased sales and no adverse impact on state government revenue.

> The study said that those results could be expected to have a minor adverse social impact. It said there is a 'weak but positive' relationship between availability of wine and alcoholism.
>
> But the study said that impact could be offset by raising the minimum drinking age and limiting wine sales around Indian reservations."

(emphasis added) Here the proposal for racial discrimination against Indians living near reservations is justified as reducing a "social impact" when in reality it is to increase state revenue from wine sales. Such efforts by non-Indians have met with little success and at best have been justifiably regarded by Indian people as discriminatory against Indians. Indian people have, themselves, recognized the alcoholism problem. In tracing the history of Indian drinking, Edward P. Dozier has noted:

> "The prohibition of liquor by tribal councils on most Indian reservations after repeal of the federal law is indicative of the Indian's own concern about abuses in drinking. The Indians' attempt to eliminate drinking have also taken on more dramatic forms. One of the most important characteristics of American Indian nativistic movements, for example, has been the condemnation of drinking as the most evil and damaging introduction of the White man. Such well known nativistic and messianic movements as the Handsome Lake cult of the Iroquois, the Ghost Dance movement of the Western tribes and the Native American Indian Church all emphasize the evils of drinking. Where native aboriginal religion is still strong, as among the Pueblo Indians of New Mexico and Arizona, liquor is strictly forbidden for participants in ceremonial ritual. The individual Indian addicted to drinking has also sought various methods of eliminating the problem; he has immersed himself deeply in native religion, or frequently he has sought a "cure" by becoming a member of various Christian sects. It is thus clear that the Indian himself is very much concerned in solving the drinking problem." [1]

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[1] Edward P. Dozier, University of Utah School of Alcohol Studies

In Montana both the Northern Cheyenne and the Crow Reservations have been "dry" since repeal of the 1832 act in 1953. From the standpoint of a realistic approach to Indian alcoholism, tribal agencies on Montana reservations have recognized alcoholism as a problem for some time. The Confederated Salish Kootenai Tribe, for example, has designated alcoholism as the reservations's number one problem and has committed substantial funding to create a very successful alcoholism treatment program.

In this study of the off-reservation alcoholism problem, one piece of existing research illustrates the sensitivity of off-reservation Indian people to the alocholism problem. In a study conducted in cooperation with the University of Montana, the off-reservation Qua-Qui Indian Alliance studied 141 Indian families residing in the Missoula area. Reflecting the mobility of Indian people in Montana, a majority of the heads of these families had lived in the Missoula area less than five years. Indians from all seven Montana reservations and the landless groups were represented in the survey. Over a third of these heads of families spoke an Indian language fluently with Flathead, Blackfeet and Cree being the most prominent. The heads of these households were asked to rank the most important problems facing them living off the reservation in Missoula County. The response is portrayed in Table VI.

TABLE VI

Ranked from most important to least important, what does the head of household think are the most important problems Native Americans face in Missoula County?

1. Employment
2. Alcoholism
3. Racial prejudice
4. Lack of education in schools
5. Housing
6. Lack of education
7. Other (i.e., transportation, lack of involvement in Indian programs, communication between people)

***

The results of this ranking of problems by Missoula's off-reservation Indians are notable in several respects. First, alcoholism is ranked second only to employment problems. A search for employment is the main reason for leaving the reservations in the first place. The documented relation between alcohol problems and employment problems is well known. Their voluntary ranking of alcoholism as second only to employment as a problem facing these off-reservation Indian people reflects a grasp of reality and an objectivity that alcoholism counselors might wish was present among the non-Indian population. Moreover, alcohol problems are ranked higher than problems of social dis-

crimination. Some Montana Indian leaders might regard ranking alcoholism problems above racial prejudice as an act selfless in the extreme on the part of these people.

While these data exist only for the off-reservation Indian population of the Missoula area at this time, interviews conducted in the course of this study indicate a substantial recognition of alcoholism problems in other Montana off-reservation areas as well. Similar surveys among Montana's other off-reservation Indian people would very likely produce similar, if not identical, results.

Alcohol and the Native American

Alcohol causes alcoholism. Why this fundamental fact is forgotten, ignored or supressed in discussion of alcoholism generally, or concerning Indian alcoholism in particular defies rational explanation. Much of the writing, mainly from anthropological sources about Indian alcoholism, avoids this crucial causal relation completely. Avoiding this relation has produced an enormous volume of speculative and highly imaginative writing on the subject of Indian alcoholism. But since it avoids the fundamental relation between ingesting a toxicant and the subsequent physical and behavioral manifestations of the effects on the human system of that toxicant, this writing has virtually no value in treatment of the disease of alcoholism among Indian people (or any other people for that matter).

The core of the confusion in writing about Indian alcoholism

stems directly from confusion within much of the general writing on and practice of alcoholism research and treatment. The reform movement in alcoholism research and treatment signaled by the merger of the National Council on Alcoholism and the American Medical Society on Alcoholism in 1973 has yet to find its way into the writing on Indian alcoholism. This confusion and consequent inappropriate treatment of alcoholics has arisen from a variety of beliefs about alcoholism which both science and common sense reject. The alcoholism reform movement, while not directed exclusively to the problem of Indian alcoholism, provides those concerned with Indian alcoholism both renewed hope and a realistic basis for creating effective treatment programs. The alcoholism reform movement is an important and crucial corrective to widely-held views of the Indian alcoholic as morally degenerate, culturally inadequate, etc. Describing the reform movement, Milam points out:

> "It is not uncommon in science for an impasse to be reached wherein data continues to accumulate, but integration is impossible until a deeply entrenched prevailing belief is finally challenged and superseded by a radically different premise. The field of alcoholism is at just such an impasse and the belief that must be overturned is none other than the most cherished certainty throughout history and in all the world today, the belief that alcoholism is caused by a symptom of a 'deeper' physchological problem. All manner of theological, cultural, and social correlates of alcoholism have been imbued with causative power and adduced in support of this psychological belief.
>
> In earlier periods demon possession or moral degeneracy in the individual were invoked as causes of alcoholism. More recently the mental health professions have inherited the problem from the

> clergy and the whole range of modern-day invectives, like 'personality inadequacy' and 'character defect', have been substituted for the earlier defamations. The semantics have changed, but the basic cultural belief has remained uncorrected that some elusive psychological peculiarity in the prealcoholic causes him to contract and progress in this most degenerate addictive disease." [1]

Some of the antropological writing on Indian drinking and alcoholism is squarely in the older mental health tradition of assuming psychological, behavioral and cultural correlates of alcoholism as somehow being causative. This mistaking of symptoms for causes in the mental health approach to alcoholism is rejected by the alcoholism reform movement:

> "In sharp contrast to the mental health belief, the rationale of the alcoholism reform recognizes that both scientific evidence and clinical knowledge point the other way -- that the obvious and profound psychosocial symptoms of the alcoholic are secondary to his unique physical reaction to alcohol as a drug. Rather than denying the importance of psychosocial variables -- the increasing tendency toward excessive drinking, regressive immaturity, loss of personal integrity, addictive drinking, mental confusion, personality inadequacy, emotional disturbance, etc. -- the viewpoint of the reform actually stresses the seriousness of these symptoms by recognizing that they are rooted from the very first onset of symptoms in the progressively adaptive, toxic, and organic effects of alcohol." [2]

Looked at from the viewpoint of the reform movement, much of the writing on Indian alcoholism and Indian alcoholic and drinking behavior needs serious modification. Modification of the older approaches to treatment of Indian alcoholism should begin with a

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[1] Milam, Ibid. P. 2

[2] Milam, Ibid. P. 3

new look at the disease of alcoholism. For treatment to be of value to Indian people, the definition of alcoholism should be rooted in this reform movement. Milam states the definition at the core of the reform movement in this way:

> "Alcoholism is a primary, progressively pathological, constitutional reaction to alcohol ingestion; psychosocial symptoms are secondary, derivative, and progressive regardless of premorbid psychosocial antecedents." [1]

Using this definition of alcoholism suggests several questions concerning alcoholism among Montana's Indian people. As leaders in the reform movement have repeatedly pointed out, alcoholism is not the product of moral degeneracy. Two leaders in the movement, Drs. Seixas and Weisman, put it this way:

> "We hope to effect a change in attitude among some medical practitioners. We shall attempt to show them that alcoholism is a respectable disease and not a moral weakness. This kind of attitude prevents some doctors from acquiring and using knowledge. The result is a needless loss of lives." [2]

The standard social stereotype of the shiftless, drunken Indian is widespread in Montana. So much so in fact that Indian people fear even clinical designation as alcoholics. This fear, reported in interviews conducted for this study, is a serious obstacle to treatment of Indian alcoholics. The widespread and mistaken notion that alcoholism is the product of moral weakness or insufficient will power is such a commonplace that both white

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[1] Milam, Ibid. P. 3

[2] Milam, Ibid. P. 3

and Indian sufferers of the disease come to believe it themselves. And, while mental health approaches tend to dress up the charges in a more complicated language, the basic moral bias remains.

Indian Drinking Patterns and Alcoholism

Writing on Indian drinking habits is replete with descriptions of bizarre behavior produced among Indians by alcohol. Much of this writing misses a major point familiar to any alcoholism researcher or counselor -- alcohol often produces bizarre behavior among all living creatures ingesting it. The explanations of Indian drinking patterns fall into three major classifications. One major classification is the anxiety explanation. This explanation purports to explain Indian drinking in terms of socioeconomic deprivation and subsequent frustration. Another major classification incorporates a loose sociocultural, psychological explanation often including suggestions that alcohol is used by Indian people, in part at least, to assist in achieving religious experience. It is important to remember, however, that the reasons for drinking have little to do with alcoholism. As Dr. Milam points out:

> "Potential alcoholics do not differ from non-alcoholics in their peer groups in any initial psychological, social, or cultural factors, and before symptoms develop they drink for all of the reasons other people do. To be sure, emotional stresses and social and cultural factors do influence the drinking rates of countless millions of drinkers." [1]

In a very perceptive review of drinking habits of the North American Indian, Dr. R. C. Dailey has pinpointed three distinct

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[1] Milam, Ibid. P. 9

phases in the history of North American Indian drinking patterns. He calls these stages accommodation, deprivation and recreation. The accommodation stage started in the 17th century and was characterized by alcohol use for newly discovered methods of seeking religious or ecstatic experience. The deprivation phase began about 1830 with the relocation to uncongenial reservations and as Dailey puts it, alcohol was used . . .

" . . . no longer to seek, as they had formerly done, but as a means of escape." [1]

Dailey's third phase, "recreation", he says, is similar to the first or "accommodation" phase and has the following characteristics:

Dailey's current or "recreation" phase:

1. Drinking remains a community-wide activity.
2. Getting drunk is highly valued and though an outlet for the release of aggressions, murders and serious maimings are not so numerous as before.
3. The object of drinking is gross intoxication.
4. Food and alcohol are seldom mixed.
5. Alcohol is always shared.
6. Little, if any, solitary drinking.
7. Moderation is practiced only by the most acculturated.
8. Drinking is noncompetitive and little, if any, value is placed on capacity.
9. No cultural controls to unbridled use.
10. There appears to be little shame or guilt associated with intoxication.

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[1] R. C. Dailey, Ph. D. Alcohol and the North American Indian: Implication for the Management of Problems; Unpublished Paper, Univ. of Utah, School of Alcohol Studies

The drinking patterns of both on and off-reservation Montana Indian people incorporate many of the characteristics outlined in Dailey's "recreational" phase. It is notable, however, that while shame and guilt seem absent, interviews in this study and data reported elsewhere in this study indicate a very high level of concern over the results of the Montana Indian drinking pattern by Indian people themselves.

One ubiquitous feature of Montana's Indian drinking pattern is "sharing". (See Dailey's fifth characteristic.) Sharing is not confined to reservation drinking but is found wherever Montana Indians congregate to drink on or off the reservation. Money to purchase alcohol is donated by members of the group according to their ability to pay. This "Frisco circle" pattern of drinking is a feature of both young and old drinkers. It occurs on the two "dry" reservations, the other five "wet" ones, and in off-reservation locations as well. The "bootlegging" operation on Montana's two "dry" reservations is well known. Private individuals purchase liquor off-reservation in retail stores or bars and sell it at inflated prices at on-reservation locations. These purchases are frequently possible through the sharing or "frisco circle" type social drinking groups.

Many writers have commented on the "binge" drinking pattern of Indian people -- the periodic group drinking bouts described by Dozier as "gang" drinking. Sometimes these descriptions lead the writers to conclude that the Indian problem is drinking and

not alcoholism. Unfortunately, this deceptively simple analysis avoids the fundamental fact that alcohol causes alcoholism. Binge or periodic drinking when it does occur among Indian people is primarily a matter of economics -- not a cultural trait. The wide use of Sterno, mouthwash and low cost wines among both on and off-reservation Montana Indians who have reached the adaptive phase of alcoholism are testimony to the important part played by the availability of ready cash for drinking purposes. This state of affairs is quite typically found among non-Indian people whose physiological needs for alcohol have progressed. The inability of some observers to accurately deal with this periodic drinking pattern and its economic base is partly due to the physical nature of the effects of alcohol on the drinker. Thus this pattern of drinking often disguises what is really happening:

> "The early onset of alcoholism usually goes unnoticed in drinking circles and undetected in professional practice for several reasons. Because of the gradual onset, and compared to the more familiar loss-of-control symptoms of more advanced alcoholism, early symptoms are easily rationalized and seem trivial to the individual and his associates. Professionls are typically trained to rationalize the symptoms, and thus participate in the patient's inverted thinking about cause and effect. Gradual compensatory adjustments often disguise differences in the individual's drinking from year to year or between his drinking and that of his companions at any point in time. The insidious physiological differences and changes are not detected in the early stages because the effects of both drinking and withdrawal are so disturbing to body chemistries that baseline differences are masked, and because when the acute effects subside the baseline differences between alcoholics and non-alcoholics are often too small to create interest or to show positive in ordinary clinical examinations. A very substantial amount of liver damage can be sustained

institutionalized drinking continues. It will not do, as some observers have done, to assume that supposedly atypical drinking behavior either prevents alcoholism or produces a different type of alcoholism among Indian or other people. Milam says in this regard:

> "Some alcoholics engage in daily maintenance drinking, some drink only on weekends, or only beer, or only wine with meals, etc. The same individual may use a variety of different control strategies during different phases of his illness. All kinds of people become alcoholic and all sorts of cultural, social, psychological, and economic factors contribute to the various styles of drinking and to various levels and strategies of control at different stages of the illness. Those who mistake these psychosocial variables for causes of alcoholism will inevitably make the additional mistake of supposing that there are multiple types of alcoholism." [1]

It is crucial for purposes of this study of Indian alcoholism in Montana for both Indian and non-Indian alike to fully understand the etiology of this disease. Data in this study show that the institutionalized pattern of drinking present on and off Montana reservations is directly related to a high incidence of alcoholism. Arguments about periodic binges, ritualistic drinking, etc., which dominate the literature on Indian drinking fail in several important respects to deal directly with what is happening among Montana Indians. Walgren and Barry's work shows conclusively that physical adaptation, tolerance to and dependence on alcohol develop with even small amounts of alcohol among some individuals. Milam summarizes the data from many studies on adaptation, tolerance and dependence

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[1] Milam, Ibid. P. 16

with these observations:

> "Although seldom fully appreciated by researchers, it is of critical importance to note that widely ranging individual differences are found in all time dose studies of physical adaptation to alcohol. Among both animals and humans some subjects display increased tolerance and physical dependence following only one low dosage trial, while at the other end of the distribution of differences, some subjects do not become physically adapted even after prolonged periods of heavy alcohol dosage. Thus the aggregate of research evidence is fully supportive of the concept of a genetic gradient of susceptibility to alcoholism, revealed in the well known variability in the durations and rates of alcohol ingestion required to precipitate the progressive alcoholic drinking pattern among different individuals and ethnic groups. Again, the psychological, social, and cultural reasons a person drinks are not relevant, and the amount consumed is relevant only in the context of the individual's susceptibility to physical adaptation." [1]

Given the institutionalized pattern of drinking among Montana Indian people and the probability of high susceptibility of adaptation to alcohol resulting in alcoholism, the mysteries surrounding high rates of Indian alcoholism in Montana disappear. The concept of a genetic gradient undoubtedly applies.

It is important to note that discussing variable rates of susceptibility to alcohol adaptation, tolerance and dependence among different individuals and ethnic groups does not imply racist overtones at all. Nor does it imply any "alcoholism gene." What it does imply is that the differentiation among individuals and ethnic groups of resistance to alcohol is great; and, this is directly in line with the research showing great individual

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[1] Milam, Ibid. P. 12

differences in all biological tolerances. Summarizing the work of R. J. Williams, Milam points out:

> "As described in eloquent detail by Williams (1971), wide individual differences are normally found in every organ and facet of physiology and biochemistry, and in biological tolerance for every common substance that people put in their bodies, including alcohol." [1]

There is, moreover, a preponderance of evidence showing that gradation in tolerances to substances, including alcohol, occur among ethnic groups. The substantial body of evidence suggesting genetic origins of differential rates of susceptibility bears directly on the high rates of alcoholism among American Indians and among Indians in Montana. In his 1972 study of ethnic differences in alcohol sensitivity, P. H. Wolff reported in Science magazine:

> "The assumption that ethnic group differences in autonomic regulation have a genetic basis is compatible with other reports of racial differences in autonomic responses to selected pharmacologic agents."

Moreover, these genetic based differential rates among different cultural groups are a world-wide phenomena according to Melzberg's The Alcoholic Psychosis. Not only does the evidence suggest differential rates of susceptibility to alcoholism among ethnic groups, it suggests Indian Americans have both high susceptability and "early age at onset" of Alcoholism. (See Table VII)

This summation of the probably effects of the genetic contribution to different ethnic group susceptibility to alcoholism can

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[1] Milam, Ibid. P. 13

TABLE VII

ALCOHOLISM EPIDEMIOLOGY

Ethnic Group	Estimated Time Exposed	Resistance	Age of Onset	Alcoholism Rate
Jew Italian	Lost in Antiquity	High	Late	Low
Irish North European	1500 years	Medium	Medium	Medium
North American Indian & Eskimo	300 years	Low	Early	High

The time exposed to alcohol refers to the time in each group that alcohol is estimated to have been available in sufficient quantity that significant numbers of the population susceptible to alcoholism could progress in their drinking and deterioration.

From: James P. Milam, The Emergent Comprehensive Concept of Alcoholism.

be extended. Sufficient quantities of alcohol available enabling significant numbers of Montana's Indian population to progress in their drinking and deterioration could not have occurred before 1860. This would mean that Montana Indians, at the most, had sufficient quantities of alcohol available for only 116 years. Moreover, while alcohol was obtainable for both reservation and off-reservation Indians it is notable that legal drinking and, therefore easily available alcohol, for off-reservation adult Indians occurred in 1953, only 24 years ago. Table VIII extends Dr. Milam's concept further to the peculiar case of the Northern Plains and Montana Indian population.

The actual period of time (150 years at most) when Northern Plains Indians had sufficient quantities of alcohol available for widespread use is clearly insufficient to develop the genetic progressions resulting in increased resistance to alcohol found in other ethnic groups using alcohol for a longer time. Moreover, intermarriage with non-Indians by Montana Indian people has been primarily with whites of North European stock who, themselves, have a fairly high rate of alcoholism and a relatively short period of substantial alcohol use. (see Table VIII). That heredity and therefore genetics play a part in susceptibility to alcoholism is clearly shown by research involving identical and fraternal twins, infants born of alcoholic mothers and in studies of enforced alcoholism among mice and subsequent alcoholism among their offspring. Consider the comparisons of Jews, Italians, and the French:

TABLE VIII

ALCOHOLISM EPIDEMIOLOGY (MONTANA REVISION)

Ethnic Group	Estimated Time Exposed	Resistance	Age of Onset	Alcoholism Rate
Jew Italian	Lost in Antiquity	High	Late	Low
Irish North European	1500 years	Medium	Medium	Medium
North American Indian & Eskimo	300 years	Low	Early	High
Montana Indian	150 years	Low	Early	High
Montana Indian Legal Drinking	23 years	Low	Early	High

" . . . The Jews and Italians after more than 15,000 years of exposure have very low susceptibilities and rates of alcoholism, and rates of attrition are also, of course, correspondingly low, Gloor (1952), Moody, and Dubos (1965). Contrary to the belief that mental illness causes or predisposes to alcoholism, it is of considerable interest that the Jews rank lowest among ethnic groups in the United States in alcoholism, while ranking highest in schizophrenia. In a different type of comparison, it is also revealing that the Italians have been exposed to alcohol in quantity for more than ten times as long as the French, and that they have only one-tenth as many alcoholics per capita as the French. These findings are all the more impressive in view of the fact that the Italians drink more alcohol per capita than the French. Which of the two ethnic groups drink more irresponsibly is not proven by this data, but the logic of the situation strongly indicates the Italians. [1]

Both logic and the data support the view of this study that an institutionalized drinking pattern and genetic predisposition combine to produce the explosive alcoholism rate among Montana Indians. The health, accident and socio-legal consequences of this explosion are obvious in any statistical treatment of the data. The human suffering involved has nothing whatever to do with psychological, moral or cultural inadequacies of Indian people. Over 20 years ago E. M. Lemert observed:

"I propose that inebriation need not in all cultures be considered, as it has so often been, as a symptom or an expression of deprivation in personality or of defective social organization. There is an alternative way of viewing drunkenness, which is to say as an institutionalized pattern operating in a relatively autonomous way and only tenuously related to the other aspects of the culture." [2]

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[1] Milam, Ibid. P. 41

[2] Lemert, E. M., Alcoholism and Sociocultural Situation, Quarterly Journal, Studies of Alcohol, 1956

Due to the institutionalized drinking pattern and a high genetic susceptibility to alcoholism, the Montana Indian is, unknowingly, the proverbial sitting duck. Becoming and remaining sober in the face of this institutionalized pattern and a high genetic susceptibility requires all the assistance and reinforcement the two cultures can muster.

Treatment and the Two Cultures in Montana

Concluding his historical survey of alcohol and the North American Indian, R. C. Dailey makes this observation:

> "At any rate, I do not think we can anticipate an appreciable moderation in the Indians' use of alcohol until one of two things happen; either they rapidly acculturate thereby losing their separate identity in the parent society or they overcome their apathy, define their drinking problem themselves (instead of letting us do it for them) and take steps, probably with our help, to do something about it." [1]

The fundamental factor of the Montana Indian's life is that he lives in two cultures -- one white and one Indian, and geographical location within Montana makes no difference. Whether on or off the reservation, life for the Indian exists within two cultures. For the off-reservation Indian, which is the focus of this section of the study, alcoholism treatment is almost totally within the context of the white culture. Interviews with Indian people and Indian alcoholism counselors in Montana indicate that the period of apathy mentioned by Dailey is rapidly expiring. The data from the Missoula Indian study and the effective action on the Salish-

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[1] Dailey, Ibid.

Kootenai Reservation and elsewhere also point to the passing of a period of apathy. Unfortunately, however, treatment for off-reservation Indians, who at any given time include substantial numbers of all Montana Indians, is wholly inadequate to the treatment tasks. Because Indian people in Montana exist within two cultures, it is commonplace for members of the majority, non-Indian culture, to ignore or suppress the fact of the minority Indian culture. Consider the following brief facts concerning the Indian presence in Montana:

1. In 1977 there are approximately 50,000 people of Indian descent in Montana.
2. There are seven Indian reservations.
3. Fourteen tribes are represented in Montana.
4. At any given time, roughly half the Indian population are probably at Montana locations off the reservations.
5. More than one out of every 20 Montanans is an Indian.
6. Only 150 years ago more Indians populated Montana than whites.
7. For a large percentage of Indians in Montana, English is a second language.
8. For a larger percentage, two languages are spoken fluently in social groups including the family.
9. Art, religion, value systems, and moral precepts are often quite distinct from those of white Montanans.
10. There has been and still exists prejudice with clear racial overtones between whites and Indians in Montana.

This brief summary does not do justice to drawing distinctions between the Indian and white culture as Indians live it in Montana.

However, it does have some very clear implications for the treatment of alcoholism in the twin cultural context of Montana.

In discussing treatment of Indian alcoholics, the Native American Rehabilitation Association (NARA) of Portland, Oregon went to the core of the problem:

> "Admittedly, limited resources do exist to help alcoholics in general. But these limited resources, even when available to Indians, are largely ineffective.
>
> Another problem is that most current programs look upon patients as a confluence of cultures rather than a parallel of cultures. The modality is White. If the Indian is willing to accept that modality and give up his own, treatment progresses. If not, the Indian is abandoned." [1]

Judging from the number of Indians repeating treatment in Montana the Indian is doubtless not abandoned in Montana, but the lack of treatment success thus indicated merely confirms the Oregon group's principal observation. Interviews with Indian and non-Indian alcoholism counselors in Montana also confirm the pertinence of the NARA observation for Montana. However, it would be overstating the case to say that all white treatment modalities in Montana fail for Indians completely. Montana Indians do get and stay sober through treatment groups. In this study, interviews with Indian alcoholism counselors and non-Indian counselors confirm, however, that the numbers are small. From the interviews in this study, it becomes clear that the major contributor to the lack of success of alcoholism treatment of Indian

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[1] NARA Narrative: Funding Application, Portland, Oregon, 1976

people in Montana is that following treatment they re-enter the cultural pattern described here as institutionalized drinking. This institutionalized drinking pattern is the product of a great variety of factors including poverty, boredom, stress, tension, desires to socialize, Indian cultural values of sharing and being together, dependence on alcohol itself, friendship, etc., all contributing to or reinforcing the pattern. And, from the point of view of continuing sobriety following treatment for Montana Indian people, very few alternatives are perceived to exist. This situation is not confined to Montana Indian people. In 1975 the Oregon Indian Commission on Alcohol and Drug Abuse reported this finding:

> "The treatment of the Indian alcoholic or drug user has so far proved ineffective or occasional. The problem with the treatment, we believe, rests with the fact that even if the Indian is detoxified or dried out, he returns to a situation that demands his continued use of alcohol or drugs." [1]

It is the view of this study that the Montana Indian's situation does not "demand" continued use of alcohol. But, it is recognized that the institutionalized drinking pattern among Montana Indians is a formidable barrier to continued sobriety for them.

Based on research in the alcoholism field, interviews with both Indian and non-Indian alcoholism counselors and others close to Montana's Indian problems, the following aspects of the problem

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[1] 1975 State Plan on Alcohol and Drug Abuse; Oregon Indian Commission on Alcohol and Drug Abuse (Stewart L. Castro, Executive Director), 1975, P. 8

are clear. Proposals for treatment of off-reservation Indian alcoholism must address the following four major factors:

1. Alcoholism among off-reservation Indians is rampant and of epidemic proportions in Montana. This situation is the product of two primary forces:
   a. An institutionalized drinking pattern leading to physical adaptation, tolerance, and dependence upon alcohol.
   b. A high susceptability to alcoholism which the evidence suggests is produced by a complex of genetic factors.
2. Indian people live in and are affected by two cultures and treatment modalities are principally grounded in the white culture only. Treatment is effective, therefore, only in the occasional cases where an individual is willing to accept treatment within only one culture -- the white, non-Indian context.
3. Upon termination of treatment, Indian people return to a social and family situation where the institutionalized drinking pattern is a principal, dominating force with little or no reinforcement for sobriety.
4. Lacking understanding of the processes of adaptation to tolerance of, and dependence on alcohol, family and social groups perpetuate the cycle of alcoholism among those already treated for alcoholism, among the young

abusers of alcohol, and among those untreated but active participants in the institutionalized drinking pattern. It is important to note that the origins for the institutionalized drinking pattern are several: poverty, boredom, feelings of hopelessness, exclusion, abandonment, the Indian concept of sharing, dependence on alcohol itself, the anxiety of trying to live in two cultures, and several others.

These four factors, then, should be the basis for planning treatment programs for Montana's Indian people. Repeatedly in interviews with Indian alcoholism counselors during the course of this study, the point has been reiterated that treatment, follow-up, and counseling should recognize that Indian people live both in white and Indian cultures; and particularly in counseling and follow-up treatment, the Indian alcoholic's cultural values should be recognized. A second major point made by Indian counselors is that return to the institutionalized drinking pattern must somehow be interrupted by some system which will reinforce sobriety -- a sober system of socializing that is a clear and workable alternative to the institutionalized drinking system. A third point emphasized by these counselors is that the family, in many cases the extended family, should be a major point of contact for counseling, both for those coming out of treatment and for purposes of education for alcoholism prevention. A fourth point emphasized by these counselors is that

while alcoholism is a problem for all Americans, the severity of the problem among Indian people calls for Indian people to plan for and participate in its solution. That Indian people are sensitive to the problem has, it is hoped, been demonstrated by the data presented in the course of this study.

While these counselors are in universal agreement that there is no such thing as "Indian alcoholism", they do generally agree that treatment and maintenance of sobriety require substantial recognition and employment of Indian cultural values. They point out, not too surprisingly, that the most effective existing follow-up program for non-Indians is an essentially non-Indian program centered on the major values of western white culture -- Alcoholics Anonymous. Moreover, the family in Montana's Indian cultures -- these counselors point out -- is of unique importance traditionally and should be, therefore, an integral part of alcoholism counseling among Indian people. (It should be noted here, incidentally, that Montana Indian families are not as dispersed geographically as is typical among white families.) Additionally, both professional practitioners in the alcoholism treatment field and Alcoholics Anonymous have discovered that family participation in the treatment process is frequently the difference between returning to alcohol and continued sobriety. There has been no widespread use of AA by Montana Indians who have had drinking problems principally for the reasons outlined above. The result is that the family involve-

ment possible in AA is not part of the picture for Indian people attempting to maintain sobriety. At any rate, conventional approaches to treatment, including AA, are successful only in small numbers of cases of Indian alcoholism in Montana. In major part this may be due to the fact that non-Indian approaches, including AA, often require the alcoholic to get deep within himself. In many cases this demands getting at resentments and hostilities which Indian people do not feel they can display in the presence of non-Indians, against whom many of these resentments and hostilities may be directed. [1]

One of the most successful treatment programs for Montana Indians is on the Salish Kootenai Reservation. This treatment program and follow-up is not AA oriented. The program includes sub-acute detox, treatment and a half-way house modality that is Indian centered. The most striking part of the program, however, is the major emphasis on family counseling. Without question, according to the director of this program, the family counseling approach is a virtual necessity for successful treatment of the Indian people dealt with in this program. In this program family counseling begins when the client is admitted to detoxification.

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[1] This is an observation of the writer reinforced by discussions with James Milam, Ph. D., Director of the Alcenas Center in Kirkland, Washington; and, of course, this observation does not apply to all-Indian AA groups.

Some Recommendations

The following recommendations are principally for off-reservation programs for Indian alcoholism. The emphasis in the course of research for this study has been the off-reservation Montana Indian alcoholism situation, and these recommendations reflect that emphasis. It should be remembered, however, that the mobility of Montana's Indian people to and from the reservation, their location in rural towns, and the relatively small cities which comprise Montana's major urban areas is a considerably different off-reservation situation than, say, Los Angeles or Seattle. The large number and size of Montana reservations, the high mobility of Indian people, the relatively small size of Montana's cities makes hard and fast distinctions between reservation and off-reservation Indian people something of a myth -- a myth, incidentally, often perpetuated by local governments for purposes of economy in dealing with costly social problems.

1. One major recommendation is that agencies dealing with Indian alcoholism recognize that Montana's Indian people are a distinct, unique, cultural minority with traditions, values and even linguistic differences, and that the Indian lives, not necessarily by choice, in two cultures.
2. A second major recommendation follows from the first. Alcoholism treatment for Montana Indian people, and particularly the follow-up portion of treatment, should be centered on these cultural distinctions. Other states,

Oregon for example, have found this to be a more successful approach.

3. A third major recommendation is that those manifestations of Indian culture which could be important to successful treatment be employed. These include, but are not limited to:
   a. the tradition of the Indian family
   b. that it is not part of the Indian cultural tradition to use alcohol (It is, after all, a white man's drug in possession of Montana Indian people less than 150 years.)
   c. Indian people communicate better with members of their own cultural group.
4. Recognize the deep concern Indian people have about alcoholism.

The following specific recommendations to deal with off-reservation Indian alcohol problems are based on the conclusions presented in this study. They represent strategies which appear to be potentially more successful than current undertakings.

1. To intercept the return to the institutionalized drinking pattern Indian people should be treated in major off-reservation locations through a series of Indian centered half-way houses and three-quarter houses.
2. Existing treatment centers treating Montana Indian people should be staffed with Indian counselors whose approach

would be an Indian cultural orientation for Indian clients.

3. Counseling of the Indian alcoholic's family within the Indian cultural context should be a major emphasis in the Indian treatment modality regardless of location.
4. Training of Indian alcoholism counselors for placement in specific, available positions utilizing existing Montana Indian training expertise such as that available at the alcoholism center on the Salish-Kootenai Reservation at Ronan.
5. Utilize the Indian family as the focus for alcoholism prevention education programs. Materials for these programs should include existing multi-media presentations developed specifically for Indian people by the University of Utah Alcoholism Center. These materials should be substantially augmented by the development of education materials specifically for Montana Indian people with a distinctly Montana and contemporary focus. These materials should be multi-media with emphasis on a visual approach.
6. All follow-up efforts including half-way and three-quarter way houses should be geared to utilizing existing manpower training resources.

CONCLUSION

The description of alcoholism among Montana Indians and recommendations for approaches to deal with the problem are based on interviews mainly, but not exclusively, with Indian people who

have had substantial training and experience in the alcoholism field. References to alcoholism research represent the best available data commensurate with existing scientific evidence. The severely depressed economic and social conditions of Montana Indians undoubtedly contribute to their drinking behavior. In the midst of this country's affluence, some of these conditions defy belief. Nevertheless, this study was concerned with drinking behavior, alcoholism and recommendations for treatment. The alcoholic, Indian or non-Indian, cannot wait for economic and social changes before he is adequately treated because, in the interval, there is a very good chance he will die.